Public Health HIGHLIGHTS

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Refugee Health Care in Utah

In 1975, Southeast Asian refugees began arriving in Utah. Since that time over 8,000 refugees have been resettled in Utah, with the majority living along the Wasatch Front. The goals of the refugee resettlement community are economic self-sufficiency and social adjustment to a new life.

The ability of refugees to successfully hold a job, study English, and pursue training is greatly dependent on their state of health and well being. Nation-wide experience has shown that refugees come to this country with a myriad of problems produced by harrowing escape experiences, long term encampment and dissolution of social and economic structures. Illness and disease are often companions to this deteriorating process. (1)

In order to identify and meet health needs of arriving refugees and assist the communities in which they resettle, the Utah State Department of Health has contracted for federal funds through the Department of Social Services and the Centers for Disease Control for the last two years and for FY 1983. This funding is channeled to local health departments to provide health screening clinics, referral, and follow-up care for arriving refugees.

In the period October 1, 1980 to September 30, 1981, 1,679 Southeast Asian refugees were screened in the local health department clinics. Of those screened, 37% were Vietnamese, 31% were Cambodian, and 32% were Laotian.

Screening examinations included a medical history taken through an interpreter, height, weight, blood pressure, tuberculin skin test, oral examination and gross skin examination. Refugees with specific complaints were examined further. Some clinics also did hematocrit, urinalysis, stool examinations, and a more detailed physical assessment on a routine basis.

At the time of screening, 49% required immunization. Most often the immunization series had been started in camps, however, few had completed the series.

The most frequent finding of public health concern was a positive tuberculin skin test; 52% of the refugees tested had positive skin tests, and, of those, 654 were started on Isoniazid (INH) preventive therapy.

There were 11 cases of current tuberculosis disease diagnosed after arrival in Utah and 19 cases diagnosed in camp were re-confirmed for a total of 30 cases during the year. Of the 30 cases: 47% were Vietnamese; 33% were Laotian; 20% were Cambodian; 60% were male and 40% female; 87% had Pulmonary Tuberculosis; and, 10% were drug resistant to INH. (See Table 1)

Table I

	0-4	5-14	15-24	25-44	45-54	55-+	All Ages
TOTAL	1	-	9	9	2	9	30
Vietnamese	1 (100)*	-	5 (56)	3 (33)	-	5 (56)	14 (47)
Khmer	-	-	2 (22)	1 (11)	1 (50)	2 (22)	6 (20)
Lao	-	-	2 (22)	5 (56)	1 (50)	2 (22)	10 (33)
Male	-	-	6 (67)	4 (44)	1 (50)	7 (78)	18 (60)
Female	1 (100)	-	3 (33)	5 (56)	1 (50)	2 (22)	12 (40)
Pulmonary TB	1 (100)	-	7 (78)	8 (89)	2 (100)	8 (89)	26 (87)
Extra-Pulm. TB	-	-	2 (22)	1 (11)	-	1 (11)	4 (13)
Drug Resistence	-	-	2 (22)	-	-	1 (11)	3 (10)

*# of persons (% of age group/total)

Source: Utah State Department of Health, 1981

- A youngster with an exotropia was seen by an ophthalmologist after being followed for years by an optometrist. The child had bilateral optic atrophy secondary to a glioma of the optic chiasm.

Even apart from the human and economic costs of misdiagnosing or failure to refer patients with medical problems to an ophthalmologist, it is a myth that vision care costs less when it is provided by an optometrist.

In *Medical Economics*, June 27, 1981, Edward N. McClean, M.D., reported a study showing that the cost of an ordinary eye examination was less when performed by an optometrist. (24.56 optometrist fee/ $34.13 ophthalmologist fee). But because the optometrist prescribed glasses more frequently, the total cost per patient was more ($102.41 optometrist/$81.22 ophthalmologist). These costs do not reflect the high rate of return visits encouraged by the optometrist (the annual or semi-annual eye exam) nor the additional cost of ophthalmologic consultation when referral is necessary.

Our office called a local optometrist to compare fees. We found that we charged one dollar more than the optometrist for a "complete" eye examination, but we charged $130.00 less for soft contact lenses!

Costs aside, the larger problem is the progressive decline in the quality of medical care in **all** specialties if the public believes it's okay to put themselves and their health in the hands of non-physicians.

We must actively counter any attempt to legalize the practice of medicine by technicians. We must not sit by and watch as podiatrists seem bent on practicing orthopedics, medexes and nurse practitioners want to practice family medicine, or lay and nurse midwives want to play an increasing role in obstetrics. Equally important is educating the public as to what constitutes quality medical care and who is and is not qualified to practice medicine.

Creating physicians by legislation rather than education is certainly contrary to the best interest of the public and in many respects is grossly irresponsible.

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At this point the concept of "collaborative practice" began its development. Some hospitals have formalized the concept and conduct regular nurse/physician committee meetings which attempt to integrate their care regimes into a single comprehensive approach to their patient's needs.

At St. Benedict's Hospital in Ogden the Alcohol and Chemical Dependency Treatment Unit has permitted the collaborative practice concept to develop over a period of years. Nurses are encouraged to take an active role in patient treatment and their clinical observations are accepted without question. Changes in treatment (within certain guidelines) may be instituted without consulting the physican. Even the admission and discharge of patients is sometimes cleared by nurses. The progress note record is used by all disciplines — psychologists, therapists, counsellors, and other paramedical personnel, as well as the physician. With this system a spirit of camaraderie develops. All personnel — not just the nurse and physician — focus on patient care and act as patient advocates. A weekly conference which brings the various disiplines together to review the patient's treatment also clears the air of misunderstandings and petty differences.

The main beneficiary from this arrangement is the patient. It quickly becomes evident that everyone is working for him. Personnel have repeatedly heard: "The spirit of caring here is fantastic! We know you are all working to help us!"

Whether or not the concept of collaborative practice proves to be the next significant development in health care remains to be seen, but it is an exciting concept that deserves careful and thoughtful evaluation.

New Members of the Utah State Medical Association:

Donald S. Coleman, M.D. 465 West 400 North Orem, Utah 84057	Anesthesiology
Michael D. Symond, M.D. 405 South Main Milford, Utah 84751	Family Practice
Sterling G. Potter, M.D. 305 Center East Carbon, Utah 84501	Family Practice